ORTHOMED CLINIC AND SUPPLY

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CONSENT TO LAM PROBE & ELECTROCOAGULATION TREATMENT

I _____authorize Orthomed Clinic and Supply and

_____ (practitioner) to use LAM PROBE/Acu Cautery on pigmented lesion or vascular lesion or telagiectasis (dialated/broken capillaries) or spider naevi or blood spots or age spots or small/large fibromas or keratosis or skin tag or clogged pores or cholesterol deposits or milia (whiteheads) or small cysts or chery angioma or hyperpigmentation treatment on me. I understand that the procedure is purely elective.

I understand that the number of treatments necessary will vary between individuals and the areas being treated. Such factors as skin color, age, hormonal activity, inherited conditions, and other influences may decrease effectiveness of treatments. Potential risks include blistering, crusting, itching, pain, bruising, skin whitening, burns, infection, scabbing, scarring, swelling, and failure to achieve the desired result.

I consent to photographs being taken to evaluate treatment effectiveness, for medical education, training, professional publications or sales purposes. No photographs revealing my identity will be used without my written consent. If my identity is not revealed, these photographs may be used and displayed publicly without my permission.

Before and after treatment instructions have been discussed with me. I have read and understand the attached exclusionary criteria. The procedure as well as potential benefits and risks have been explained to my satisfaction. I understand that compliance with recommended pre and post procedure guidelines are crucial for healing, prevention of scarring, and other side effects and complications such as hyper pigmentation, hypo pigmentation, and other skin textural changes. I have had all questions answered. I freely consent to proposed treatment.

No guarantee, warranty, or assurance have been made to me as to the results that may be obtained. I am aware that follow-up treatments may be necessary for desired results. Most patients require a number of treatments over several months with gradual results occurring over this time. Clinical results will vary per patient. I agree to adhere to all safety precautions and regulations during the treatment. No refunds will be given for treatments received.

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

The nature and purpose of the treatment have been explained to me. I have read and understand this agreement. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. Alternative methods of treatment and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment.

Occasionally, unforeseen mechanical problems may occur and your appointment will need to be rescheduled. We will make every effort to notify you prior to your arrival to the office. Please be understanding if we cause you any inconvenience.

I release Orthomed Clinic and Supply and all medical staff, and specific technicians from liability associated with this procedure. I certify that I am a competent adult of at least 18 years of age. This Consent Form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns. Note: All prices are subject to change without prior notice.

This is to confirm that I do NOT consent to reveal/release my file and all confidential information pertaining to my treatments and any related services to any third party.

CLIENT SIGNATURE_____ Date_____

PRACTITIONER SIGNATURE _____Date_____